DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 1002 (Rev. 12/02)

STATE OF WISCONSIN
Health Check

HEALTHCHECK INDIVIDUAL HEALTH HISTORY

	Current Medical Assistance I.D. Number Per Code
Fill out one form for each person screened	Date Completed (Month / Day / Year)
Name - Patient	Name - Parent or Guardian
Address – Patient	Address – Parent or Guardian
Telephone – Patient	Telephone – Parent or Guardian
Birth Date – Patient (Month / Day / Year)	
School and Grade or Occupation – Patient	
Name and Address - Physician	
Name and Address - Dentist	

GENERAL HEALTH - Answer for All Ages

Office Use	Yes	No	Don't Know	
1				Has it been more than 12 months since this person had a general checkup by a physician?
2				Has it been more than 12 months since a physician examined this person because of illness or injury?
3				Has it been more than 12 months since this person had a general checkup by a dentist?
4				Has it been more than 12 months since a dentist examined this person because of illness or injury?
5				Is there anything about this person's health, growth or development that you are concerned or worried about? If YES, explain.
6				Does this person always use a seatbelt or car seat in an automobile?

DID THIS PERSON EVER HAVE OR DOES THIS PERSON NOW HAVE ANY OF THE FOLLOWING?

Office Use	Yes	No	Don't Know		Office Use	Yes	No	Don't Know	
7				Unexplained fever	20				Vomiting or diarrhea
8				Poor appetite or feeding problem	21				Wheezing or noisy breathing
9				Loss of weight	22				Swollen joints
10				Loss of consciousness, fainting	23				Heart murmur
11				Head injury	24				Frequent stomach aches
12				Seizure, convulsions, fits	25				Blood in bowel movements
13				Frequent headache	26				Bladder, kidney, or urinary problems
14				Eye trouble	27				Blood in urine
15				Earaches, draining ears	28				Rashes, eczema, hives, skin problems
16				Frequent nosebleeds	29				Many bruises or bleedings
17				Chronic cough	30				Frequent stumbling, falling
18				Hearing problems	31				Frequent colds or infections
19				Constipation					

Office Use	Yes	No	Don't Know	HAS THIS PERSON HAD ANY OF THE FOLLOWING?
32				
				Rubella (German measles)
				Measles (Red)
				Mumps
				Rheumatic Fever
33				Did or does this person have allergies? If YES, describe.
34				Did or does this person have asthma?
35				Has this person had any serious accidents? If YES, describe.
36				Has this person had any hospitalizations, operations, major illness? If YES, describe.
37				Does this person now have any problems which you feel, or which a physician has told you, may be related to any one of the conditions 7 – 36? If YES, describe.
38				Does this person OFTEN eat things which are not usually considered to be food? (Example: dirt, paint chips, crayons, clay, starch, newspaper.) If YES, describe.
39				Does this person have problems with toileting or toilet training?
40				Does this person get along with family members and playmates?
41				Does this person have difficulty learning?
42				Does this person get into trouble in school or dislike school?
43				Has this person taken prescription medicines in the last 12 months? For what?
44				Has this person taken non-prescription medicines in the last 12 months? (Example: aspirin, antihistamines, vitamins, food supplements.) If so, what medications?
45				Has this person ever had a positive reaction to a tuberculosis test?
46				Referred for Adolescent Review.
47				ANSWER FOR FEMALES BORN BEFORE 1972: Did the mother of this person take any medications to prevent miscarriage during this pregnancy?

IMMUNIZATION HISTORY: Give the date this person received each of the following.

Type (Recommended Dose)	None	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
DTP (Diphtheria, tetanus, and whooping cough) (5 dose by school entrance)						
Td (Tenanus) (every 10 years after school entrance)						
Polio Oral (by mouth) (4 dose by school entrance)						
Measles, Mumps, Rubella (2 dose by school entrance)						
Hemophilus Influenza, Type B (at 2, 4, 6 and 15 months)						

BEHAVIORAL / EMOTIONAL HEALTH

Office Use	Yes	No	Don't Know	
47				Does this person have a history of either: ● Behavioral or emotional problems OR ● Treatment for behavior or emotional problems at a ● Clinic or hospital? If YES for any, explain.
48				Has anyone in this person's family ever been treated or hospitalized for emotional problems such as depression, anxiety, mood swings, suicide attempts, or alcohol or drug abuse? If YES for any, explain.
49				Has this person ever abused alcohol and/or drugs? If YES, explain.

50 Has this person ever

- ☐ felt hopeless or depressed
- ☐ had unexplained crying spells
- ☐ planned or attempted suicide
- ☐ had peculiar or bizarre thoughts
- ☐ had trouble eating or sleeping (too much or too little)
- ☐ had an excess of energy or activity
- ☐ felt like hurting him/her self
- ☐ displayed reckless or dangerous behavior
- ☐ heard things no one else around them heard
- ☐ show inappropriate emotions (reactions that don't make sense for the situation)

51 Does this person have any of these problems at school?

- ☐ poor grades
- ☐ difficulty in making friends
- ☐ frequent suspensions from schools
- ☐ fighting or arguing with peers or teachers
- ☐ frequently lying or stealing
- ☐ frequently cutting classes or playing hooky

52 Has this person had any of the following problems at home or in the community?

- ☐ withdrawing socially (doesn't want to be around other people)
- ☐ lying or stealing
- ☐ arguing or fighting with peers or brothers or sisters
- ☐ clinging excessively to a parent, teach, or other person
- ☐ running away from home
- ☐ problems with police
- ☐ refusing to follow instructions from parents, or obey the house rules, etc.

Criteria for Referral for Further Assessment

47. and 49. Refer for a psychiatric assessment if there is a positive response.
48. Refer only if referred criteria are met for any other question.
50. Refer for a psychiatric assessment if any responses are checked.
51. and 52 Refer for a psychiatric assessment if two or more responses are checked.

PREGNANCY & DEVELOPMENT

Answer for all Ages

BIRTH ORDER of this person. Indicate by placing a check mark in the appropriate box whether this person was the first, second, etc. Do not count stillborn brothers or sisters.

☐ 1st	☐ 2nd	☐ 3rd	☐ 4th	☐ 5th	☐ 6th	☐ 7th	☐ 8th	☐ 9th	☐ 10th or over
MOTHER'S AGE AT THIS BIRTH		Check one	☐ Under 17		☐ 17-39		☐ 40 and over		☐ Unknown
FATHER'S AGE AT THIS BIRTH		Check one	☐ Under 17		☐ 17-39		☐ 40 and over		☐ Unknown

53	Yes	No	Don't Know	**MOTHER'S PREGNANCY HISTORY-**Answer only for children UNDER 6 YEARS
				Was there any bleeding during this pregnancy?
				Was the baby born early? If so, how many weeks?
				Was there other difficulty or illness during this pregnancy? (Examples: rubella or german measles, high blood pressure, high blood sugar, sexually transmitted diseases, etc.) If YES, describe.
				Were any X-rays taken during pregnancy?
				Were any prescription or other drugs taken during pregnancy? (Examples: tranquilizers, antibiotics, sedatives, medicines for vomiting, medicines – shot or oral – to prevent miscarriage or bleeding.) If YES, describe.
				Were any non-prescription medications taken during pregnancy? (Examples: vitamins, iron supplements, frequent aspirin, etc.) If YES, describe.
				Was there anything unusual about the labor or delivery? If YES, describe.
54				**DEVELOPMENTAL MILESTONES-**Answer only for children UNDER 6 YEARS

Birth Weight: _____lbs. _____ozs. Length _____ inches

Check the appropriate time this child did each of the following.

Follow object with eyes	**Roll over**	**Turn to voice**	**Sit alone**	**Act shy with strangers**
☐ Not yet	☐ Not yet	☐ Not yet	☐ Not yet	☐ Not yet
☐ Before 1 month	☐ Before 2 months	☐ Before 3 months	☐ Before 5 months	☐ Before 5 months
☐ 1 - 4 months	☐ 2 - 5 months	☐ 3 - 8 months	☐ 5 - 9 months	☐ 5 - 10 months
☐ After 4 months	☐ After 5 months	☐ After 8 months	☐ After 9 months	☐ After 10 months

Walk alone	**Speak single word**	**Speak simple sentences**	**Eat finger food along**	**Use cup alone**
☐ Not yet	☐ Not yet	☐ Not yet	☐ Not yet	☐ Not yet
☐ Before 11 months	☐ Before 9 months	☐ Before 20 months	☐ Before 2 years	☐ Before 2 years
☐ 11 - 15 months	☐ 9 - 12 months	☐ 20 mo. - 2 ½ years	☐ After 2 years	☐ After 2 years
☐ After 15 months	☐ After 12 months	☐ After 2 ½ years		

Permission is hereby granted for health screening for early detection of health problems for _____
(Name of Patient)
and for the release of resulting information to appropriate health care providers and health authorities. Permission is also granted to such health care providers and health authorities to release information to personnel conducting this health-screening program.

_____ _____ _____

SIGNATURE Relationship to Patient Date Signed